Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DENTON REGIONAL MEDICAL CTR
10030 N MACARTHUR BLVD SUITE 100
IRVING TX 75063

Respondent Name
Zurich American Insurance Co

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-3173-01

MFDR Date Received
June 19, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review for medical necessity."

Amount in Dispute: $14,697.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written notification of medical fee dispute acknowledged however, no response submitted.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
February 3, 2012	Outpatient Hospital Services	$14,697.88	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective review of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 16, 2012
   - 19 –(197) PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.

   Explanation of benefits dated May 25, 2012
   - 19 – (197) PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT
   - 19 – (197) THIS LINE WAS INCLUDED IN THE RECONSIDERATION OF THIS REVIOUSLY REVIEWED BILL

Issues

1. Did the respondent support the insurance carrier's reason for denying disputed services?

Findings

1. The insurance carrier denied disputed services billed with reason code j19 – (197) – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT." Per 28 Texas Administrative Code §134.600(c)(1), effective May 2, 2006, 31 *Texas Register* 3566, the carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) only in the case of an emergency or "preauthorization of any health care listed in subsection (p) . . . that was approved prior to providing the health care." §134.600(p)(2) states that the non-emergency health care requiring preauthorization includes "outpatient surgical or ambulatory surgical services." Documentation was not found to support that this surgical service had been preauthorized. The insurance carrier's denial reason is supported.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 3, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.